Filing at a Glance

Company:	UnitedHealthcare Insurance Company
Product Name:	UHC Short Term Travel
State:	District of Columbia
TOI:	H19G Group Health - Travel
Sub-TOI:	H19G.000 Health - Travel
Filing Type:	Form
Date Submitted:	11/09/2016
SERFF Tr Num:	INCS-130800949
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	POL.STT.I.13.F
Implementation Date Requested:	On Approval
Author(s):	Renee Weaver
Reviewer(s):	Angela King (primary), Colin Johnson
Disposition Date:	
Disposition Status:	
Implementation Date:	

General Information

Project Name: UHC POL.STT.I.13
Project Number: UHC POL.STT.I.13
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 11/10/2016
State Status Changed:
Created By: Renee Weaver
Corresponding Filing Tracking Number: INCS-130800948

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 01/08/2014
Domicile Status Comments: does not require prior approval
Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Deemer Date:
Submitted By: Renee Weaver

Filing Description:
UnitedHealthcare Insurance Company
NAIC No. 79413
H19G.000 Travel
Group Short Term Travel Product Filing

On behalf of UnitedHealthcare Insurance Company, Innovative Compliance Solutions, LLC is submitting the enclosed group Short Term Travel product for your Department's review and approval. An authorization letter is attached.

This is a new product filing. The rates for this product were filed under SERFF filing number INCS-130800948.

Our intent is to use these forms for fully insured large employer groups only. The enclosed forms include:

Group Policy, POL.STT.I.13.DC
Certificate of Coverage, COC.STT.I.13.DC
Schedule of Benefits, SBN.STT.I.13.DC
Accidental Death and Dismemberment Rider, STT_I_13_ADD_RID.DC
Insured Short Term Travel Employer Application, LG.ER.15.GS.STT.DC 3/15
Insured Employer Application, LG.ER.15.GS.DC 3/15
Employee Application, LG.EE.15.GS.DC 3/15

The Short Term Travel product provides business travelers who require temporary coverage while travelling outside their home country. The Short Term Travel product is a fully insured supplemental product that provides coverage in addition to a group's base medical product. As you know, supplemental travel plans are excepted benefits and are not required to comply with ACA requirements.

Some of the Core and Optional coverage highlights are noted below:

Core Coverage:
•Worldwide coverage for emergency and urgent care medical services due to accident or sickness while travelling outside the home country
•Suite of standard plan designs to be offered with medical limit maximums from $100,000 to $500,000
•Evacuation Benefits (emergency medical evacuation, medical repatriation and return of mortal remains)

•Global concierge and travel assistance services (e.g., legal referrals and emergency translation services)

Optional Coverage:
•Accidental Death and Dismemberment (AD&D)
•Dependent Coverage
•Sojourn Travel (leisure travel in conjunction with a business trip)

Explanation of Variable Text
The form is made up of:
•Nonvariable Text that always appears in an issued document.
•Variable Text that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets]. Variable text will appear unbracketed in the final documents issued to the employer and/or member.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Renee Weaver
Consultant
Innovative Compliance Solutions, LLC
Ph: 763-323-8643
Email: rweaver@innovative-compliance.com

Company and Contact

Filing Contact Information

Renee Weaver, Consultant
PO Box 773
Anoka, MN 55303

rweaver@innovative-compliance.com
763-323-8643 [Phone]
763-712-8001 [FAX]

Filing Company Information

(This filing was made by a third party - innovativecompliancesolutions)

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103
(800) 357-1371 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No

State:	District of Columbia	**Filing Company:**	UnitedHealthcare Insurance Company
TOI/Sub-TOI:	H19G Group Health - Travel/H19G.000 Health - Travel		
Product Name:	UHC Short Term Travel		
Project Name/Number:	UHC POL.STT.I.13/UHC POL.STT.I.13		

Fee Explanation:

SERFF Tracking #:	*INCS-130800949*	***State Tracking #:***		***Company Tracking #:***	*POL.STT.I.13.F*

State:	*District of Columbia*	***Filing Company:***	*UnitedHealthcare Insurance Company*
TOI/Sub-TOI:	*H19G Group Health - Travel/H19G.000 Health - Travel*		
Product Name:	*UHC Short Term Travel*		
Project Name/Number:	*UHC POL.STT.I.13/UHC POL.STT.I.13*		

Form Schedule

Lead Form Number: POL.STT.I.13.DC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		GROUP POLICY	POL.STT.I.13.DC	POL	Initial		49.100	Group Policy POL.STT.I.13.DC.pdf
2		CERTIFICATE	COC.STT.I.13.DC	CER	Initial		44.600	Certificate of Coverage R3 2016 - COC.STT.I.13.DC filing copy.pdf
3		SCHEDULE OF BENEFITS	SBN.STT.I.13.DC	SCH	Initial		47.200	Schedule of Benefits X13I_SBN-STT-R2 2016 - SBN.STT.I.13.DC.pdf
4		AD&D RIDER	STT_I_13_ADD_RID.DC	CERA	Initial		48.900	Accidental Death and Dismemberment Rider STT_I_13_ADD_RID.DC.pdf
5		SHORT TERM TRAVEL EMPLOYER APP	LG.ER.15.GS.STT.DC 3/15	AEF	Initial		50.200	M53901-C DC short term travel form 3 15.pdf
6		INSURED EMPLOYER APPLICATION	LG.ER.15.GS.DC 3/15	AEF	Initial		50.200	LG.ER.15.GS.DC 315.pdf
7		EMPLOYEE APPLICATION	LG.EE.15.GS.DC 3/15	AEF	Initial		52.500	LG.EE.15.GS.DC.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage

SERFF Tracking #:	*INCS-130800949*	***State Tracking #:***		***Company Tracking #:***	*POL.STT.I.13.F*

State:	*District of Columbia*	***Filing Company:***	*UnitedHealthcare Insurance Company*
TOI/Sub-TOI:	*H19G Group Health - Travel/H19G.000 Health - Travel*		
Product Name:	*UHC Short Term Travel*		
Project Name/Number:	*UHC POL.STT.I.13/UHC POL.STT.I.13*		

OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Group Policy

UnitedHealthcare Insurance Company

[185 Asylum Street]

[Hartford, Connecticut 06103-3408]

[1-800-357-1371]

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide supplemental Benefits for Covered Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. Benefits under the Policy are designed to provide supplemental coverage while a Subscriber is traveling outside [his or her home country] [the *United States*] [[solely] [primarily] for the purpose of business, as authorized by the Enrolling Group]. These Benefits will be used to supplement those of an existing medical plan which provides coverage for services provided within the [Subscriber's home country] [*United States*]. [Benefits are also available during sojourn travel, which is leisure travel in conjunction with the original trip. This extended travel can take place before, during or after the original trip.]

The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company

[Signature of authorized company officer]

[Title of authorized company officer]

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 8: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes.

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Article 2: Benefits

Subscribers are entitled to Benefits for Covered Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Subscribers are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation relating to health status that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than [30 - 90] days prior to the date we received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing within [30 - 90] days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will automatically be added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation will result in an increase in Premium in an amount we determine.

3.4 Payment of the Policy Charge

[Variable provisions apply when advance payment is supported in Exhibit 1.]

The Policy Charge is payable to us [in advance] by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. [The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.]

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked “paid in full”, “without recourse”, or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

[1 Include when grace period provision applies.]

[2 Include when grace period provision does not apply.]

A late payment charge will be assessed for any Policy Charge not received [1within [10 - 45] calendar days following the due date.] [2by the due date.] A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Subscribers for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

[3.5] [Grace Period]

[A grace period of [30 - 90] days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.]

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

[4.3] [Open Enrollment Period]

[An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.]

[4.4] Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons is stated in Exhibit 2.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Services under this Policy will automatically terminate on the earliest of the dates specified below:

[1Include when grace period applies and coverage terminates on the last day of the grace period.]

[2Include when grace period does not apply and coverage terminates on the last paid date.]

[3Include when grace period applies and coverage terminates on the last paid date.]

A. [1On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.] [2At our option, retroactive to the last paid date of coverage if the Policy Charge remains unpaid on the due date.] [3At our option, retroactive to the last paid date of coverage if the grace period expires and the Policy Charge remains unpaid on the due date.]

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

[Include when either contribution or participation rules apply.]

[C.] [On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the [participation] [and][or] [contribution] rule[s] as shown in Exhibit 1.]

[D]. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

- The effective date of this Policy.
- The date of the act, practice or omission, if later.

[E.] On the date agreed to by the Enrolling Group and us.

[F.] On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

[G.] On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

6.2 Dispute Resolution

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy.

Arbitration will take place in [Hartford County, Connecticut].

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by controlling law.

6.3 Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

6.4 Amendments and Alterations

Amendments to this Policy are effective 31 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Other than changes to Exhibit 2 stated in a Notice of Change to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

6.5 Relationship between Parties

The relationships between us and Enrolling Groups are solely contractual relationships between independent contractors. Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Enrolling Groups.

The relationship between a provider and any Subscriber is that of provider and patient. The provider is solely responsible for the services provided by it to any Subscriber. The relationship between any Enrolling Group and any Subscriber is that of employer and employee or any other category of Subscriber described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Subscriber's coverage) and for the timely payment of the Policy Charges.

6.6 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.

- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Subscriber authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Subscriber. We have the right to request this information at any reasonable time. This applies to all Subscribers whether or not they have signed the enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.7 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

[6.8] [Employee Retirement Income Security Act (ERISA)]

[When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.]

[6.9] Examination of Subscribers

In the event of a question or dispute concerning Benefits for Covered Services, we may reasonably require that Physician, acceptable to us, examine the Subscriber at our expense.

[6.10] Clerical Error

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Subscriber beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than [30 - 90] days of coverage prior to the date we received notification of the clerical error.

[6.11] Workers' Compensation Not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

[6.12] Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

[6.13] Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers. The Enrolling Group is responsible for giving notice to Subscribers on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

[6.14] Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to [the Enrolling Group for delivery to] each Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at [www.myuhc.com].

[6.15] System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and _____, the Enrolling Group.

2. **Effective Date of this Policy.** The effective date of this Policy is 12:01 a.m. on [_____, 20__] in the time zone of the Enrolling Group's location.

[1ERISA groups.]

[2Non-ERISA groups.]

3. **Place of Issuance.** We are delivering this Policy in the State of the District of Columbia. [1This Policy is governed by ERISA. To the extent that state law applies, the laws of the State of the District of Columbia are the laws that govern this Policy.] [2The laws of the State of the District of Columbia are the laws that govern this Policy.]

[1Include when premiums are specified in the Cost Summary.]

[2Include when the group has more than 1 class.]

[3Select the appropriate length of time for prior written notice, based on group requirement.]

[4Select the text that describes when we have the right to change premium.]

4. **Premiums.** We reserve the right to change the *Schedule of Premium Rates* [1or *Cost Summary*] specified in [2each] Exhibit 2, after a [331 - 120]-day prior written notice [4on the first anniversary of the effective date of this Policy specified in the application or on any monthly due date thereafter, or on any date the provisions of this Policy are amended. We also reserve the right to change the *Schedule of Premium Rates*, retroactive to the effective date, if a Material Misrepresentation relating to health status has resulted in a lower schedule of rates.] [4at any time.]

5. **Computation of Policy Charge.** [A full calendar month's Premiums will be charged for Subscribers whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Subscribers whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Subscribers whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Subscribers whose coverage is terminated on or before the 15th of that calendar month.]

   [A pro rata Premium, calculated on the number of days Subscribers are actually covered under this Policy, will be charged for Subscribers whose effective date of coverage falls on a date other than the first of the month or for Subscribers whose coverage is terminated on a date other than the first of the month.]

   [A full month's Premium will be charged for any Subscriber who is covered under this Policy for any portion of a calendar month.]

   [A per trip Premium will be charged for any Subscriber who is covered under this Policy.]

   [A flat amount Premium will be charged for any Subscriber who is covered under this Policy.]

6. **Payment of the Policy Charge.** The Policy Charge is payable to us [in advance] by the Enrolling Group [on a [monthly] [quarterly] [semi-annual] [annual] [per trip] [flat amount] basis] [as follows: _____].

7. **Minimum Participation Requirement.** [The minimum participation requirement for the Enrolling Group is [[2 - 101] Eligible Persons.] [[0 - 100]% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.][The Minimum Participation Requirement does not apply.]

8. **Minimum Contribution Requirement.** [The Enrolling Group must maintain a minimum contribution requirement of [0 - 100]% of the Premium for each Eligible Person.][The Minimum Contribution Requirement does not apply.]

9. **Notice.** Any notice sent to us under this Policy must be addressed to:

_____

(Name of Issuing Entity)

_____

(Address)

_____

(City, State, Zip)

Any notice sent to the Enrolling Group under this Policy must be addressed to:

_____

(Enrolling Group)

_____

(Address)

_____

(City, State, Zip)

[10]. [____ Enrolling Group Number]

[[1]Include when more than one class of Eligible Persons is covered.]

Exhibit 2 [[1]Class [1-10]]

[Include when the group has more than 1 class.]

[The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.]

1. **Class Description.**

   [All full-time employees.] [See Application.]

[[1]Include when more than one class of Eligible Persons is covered.]

2. **Eligibility.** The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* [[1]applicable to this class]:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

   [_____]

   B. Other:

   [_____]

[3]. **[Open Enrollment Period.** [An Open Enrollment Period of at least [30 - 60] days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on [an annual basis] [a quarterly basis] [_____].][No Open Enrollment Period applies to this class.]**]**

[4]. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is [_____].

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is [the day following the last day of the required waiting period.] [the first day of the month following the last day of the required waiting period.] [the date the Eligible Person joins the Enrolling Group.] [the first day of the month following the date the Eligible Person joins the Enrolling Group.][as determined by the Enrolling Group, _____.] Any required waiting period will not exceed 90 days.

[5]. **Schedule of Premium Rates.**

[The *Schedule of Premium Rates* payable by or on behalf of this class of Subscribers as of [_____] is shown below:

[**Coverage Classification]**	[**Monthly Premium]**	**[Per Trip Premium]**	**[Flat Premium]**
Subscriber	$XXX.XX	$XXX.XX	$XXX.XX

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.]

[Monthly Premiums payable by or on behalf of Subscribers are specified in the *Cost Summary*.]

[Monthly Premiums payable by or on behalf of Subscribers are specified in the *Cost Summary* detailed through the new business premium confirmation process and renewal package.]

[Exhibit 3 - Miscellaneous Provisions]

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

THE POLICY PROVIDES COVERAGE THAT IS SUPPLEMENTAL TO A DOMESTIC GROUP HEALTH PLAN. IT IS NOT A MAJOR MEDICAL OR COMPREHENSIVE MEDICAL POLICY.

The Policy covers Emergency Health Services and urgent care services. The Policy also covers emergent care services (services that if not provided would likely result in a Covered Person's hospitalization).

[1]Include only if Policy is issued to support business travel and select "primarily", "solely" or "for the purpose of business" as applicable.

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide supplemental Benefits to Subscribers, subject to the terms, conditions, exclusions and limitations of the Policy. Benefits under the Policy are designed to provide supplemental coverage while a Subscriber is traveling outside [his or her home country] [the *United States*] [[1][solely] [primarily] [for the purpose of business], as authorized by the Enrolling Group.] These Benefits will be used in conjunction with those of an existing medical plan which provides coverage for services provided within the [Subscriber's home country] [*United States*]. [Benefits are also available during sojourn travel [for the Subscriber] [and [1 - 12] [family member[s] [and Domestic Partner]], which is leisure travel in conjunction with the original trip. This extended travel can take place before, during or after the original trip. Benefits for sojourn travel are limited to [2 - 90] days.]

We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of the District of Columbia. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of the District of Columbia are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Subscribers, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber as that term is defined in *Section 8: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Services. The extent of this Benefit plan's payments for Covered Services and any obligation that you may have to pay for a portion of the cost of those Covered Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Services, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Services

We pay Benefits for Covered Services as described in *Section 1: Covered Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay for Covered Services

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. Providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies [by going to [www.myuhc.com] or] by calling *Customer Care* at the telephone number on your ID card.

Certificate of Coverage Table of Contents

Section 1: Covered Services

Benefits for Covered Services

Benefits are available only if all of the following are true:

- The medical service, supply or Pharmaceutical Product is only a Covered Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, mental illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Service under the Policy.
- Covered Services are received outside [the Subscriber's home country] [the *United States*] and only while the Policy is in effect.

[1]*Include only if Policy is issued to support business travel and select "primarily", "solely" or "for the purpose of business" as applicable.*

- Covered Services are received by a Subscriber who is traveling outside [his or her home country] [the *United States*] [[1][primarily] [solely] [for the purpose of business], as authorized by the Enrolling Group].
- Covered Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Services is a Subscriber and meets all eligibility requirements specified in the Policy.

This section describes Covered Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Services (including any Annual Deductible, Copayment and/or Coinsurance).

[1]*Include when an Annual Maximum Benefit applies.*

- Any limit that applies to these Covered Services (including visit, day and dollar limits on services[[1], any Annual Maximum Benefit,] and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Medical Benefits

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.

- From an acute facility to a sub-acute setting.

Include when plan provides benefits for Culturally-Based Services.

[2.] [Culturally-Based Services]

[Services provided outside the *United States* that reflect the medical standards of the country in which the service is provided, but which may otherwise be considered alternative treatments when provided within the *United States*. Benefits for culturally-based services are available only when we determine that the service or supply meets the following criteria:

- It is care or treatment that is as likely to produce a significant positive outcome as (and no more likely to produce a negative outcome than) any alternative service or supply, both as to the Sickness or Injury involved and the Subscriber's overall health condition.
- It is a diagnostic procedure indicated by the health status of the person that is as likely to result in information that could affect the course of treatment as (and no more likely to produce a negative outcome than) any alternative service or supply, both as to the Sickness or Injury involved and the Subscriber's overall health condition.
- It is diagnosis, care and treatment that is no more costly than any alternative services or supply to meet the above tests, taking into account all health expenses incurred in connection with the service or supply.]
- Include when group purchases dental pain relief benefit.

[3.] [Dental Pain Relief - Emergency Only]

- Emergency dental treatment for the immediate relief of pain (for natural teeth) solely to relieve distress in eating.]

Include when group purchases accidental dental benefit.

[4.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- [Emergency dental pain.]
- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.

- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

Include when group purchases durable medical equipment benefit.

[5.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or

Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

Include when DME Benefit is tiered and tiers are not to be included in COC.

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

Include when DME Benefit is tiered and tiers are to be included in COC.

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps.
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[6.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Include if plan design includes retrospective review of emergency services.

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

[7.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds). If a Semi-private Room is not available, Benefits will be provided for the lowest cost private room.

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

- [[1]Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Emergency room Physicians. (Benefits for all other Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.)]

[8.] Lab, X-Ray and Diagnostics - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office] include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[9.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[1]Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Include when outpatient prescription drugs are covered under the medical plan.

[10.] [Outpatient Prescription Drugs]

[Outpatient prescription drugs that are prescribed for you by your Physician to treat a Sickness or Injury for which Benefits are provided as described in this *Certificate*. Benefits for outpatient prescription drug products are available when the outpatient prescription drug product meets the definition of a Covered Service. Benefits are not available for over the counter drugs or other drugs or treatments available without a prescription. Prescriptions must be paid for out-of-pocket by the Subscriber and submitted to us for reimbursement.]

[11.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Subscriber's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

[12.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

[13.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

[Covered Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.

- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.]

Benefits under this section include allergy injections.

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. [2]Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.

[[1]Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [[2]Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.]]

[3]Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.

[[3]When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[1]Include when group purchases Benefits for Maternity Services.

[2]Include when group purchases Benefits for Complications of Pregnancy only

[14.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]

[1]Include #1 below when Benefits are available for full Maternity Services and delete option #2 further below.

[[1]Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Subscribers in the immediate family. Covered Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.]

[2]Include #2 below when Benefits are available only for Complications of Pregnancy and delete option #1 above.

[[2]Benefits for Complications of Pregnancy include all Covered Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Subscribers in the immediate family. Covered Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

Include when group purchases benefits for prosthetic devices.

[15.] [Prosthetic Devices]

[External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis, mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.]

[16.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Subscriber may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[17.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[1]Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[18.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

- [[1]Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Benefits for Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.]

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Subscribers who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

[19.] Surgery - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[20.] Therapeutic Treatments - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office], including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[2]Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[21.] Urgent Care Center Services

Covered Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Evacuation and Repatriation Benefits

Include when plan provides benefits for emergency evacuation.

[1.] [Emergency Medical Evacuation]

[If you suffer a Sickness or Injury and adequate medical facilities are not available locally in the opinion of our *Medical Director* or the *Medical Director* of our affiliate or authorized vendor under our direction, we will provide emergency evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. Covered Services include arranging and providing for transportation and related medical services (including cost of medical escort) and medical supplies necessarily incurred in connection with the emergency evacuation.

[Includes:

- [Evacuation of [1 – 12] [immediate] family members.]
- [A traveling companion]
- [Evacuation of children (under the age of 18) either to the same location as the Covered Person or to a location where the children can be placed under the care of another guardian or relative.]
- [A per diem for living expenses for [companion] [family members] [children] while member is hospitalized.]

[We will pay for you to return to where you were evacuated from. We must approve in advance all arrangements for your return and you must make the return journey within 14 days of the end of the treatment for which you were repatriated.]

[Includes:

- [Return of [1 – 12] [immediate] family members.]
- [Includes return of children (under the age of 18).]
- [Includes a traveling companion.]

[[First class] [Business Class] [Economy class] travel is provided]

[2.] [Emergency Family Reunion]

[In the event that you are hospitalized and in a critical or terminal condition,
Benefits are available for your family members to join you. This includes the cost of round trip travel and lodging.]

Include when plan provides benefits for medical repatriation.

[3.] [Medical Repatriation]

[After you receive initial treatment and stabilization for a Sickness or Injury, if the attending Physician and our *Medical Director* or the *Medical Director* of our affiliate or authorized vendor under our direction determine that it is medically necessary, we will transport you back to your permanent place of residence for further medical treatment or to recover. Covered Services include arranging and providing for transportation and related medical services (including medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Benefits are available for medical repatriation, provided that both of the following apply:

- The treatment required is a Covered Service.
- The treatment is recommended by your Physician.

You must provide us with any information or proof that we may reasonably request.

Benefits for medical repatriation are only available if all arrangements for your repatriation are approved in advance and arranged by us. Physicians from our appointed representatives will discuss all relevant factors with your own Physician before authorizing payment for repatriation.

[1]Include when plan provides benefits for companion travel.

[2]Include when plan provides benefits for domestic partners.

[3]Include when companion travel benefits are limited.

[[1]Benefits are also provided for the reasonable travel costs for your relative [[2]or your Domestic Partner] to accompany you if authorized in advance of the repatriation [[3]and are limited as stated in the *Schedule of Benefits*].

[Includes:

- [Travel costs of [1 – 12] [immediate] family members.]
- [Travel costs of traveling companion.]
- [Repatriation of children (under the age of 18).]
- [A per diem for living expenses for [companion] [family members] [children] while member is hospitalized.]

[We will pay for you to return to where you were repatriated from. We must approve in advance all arrangements for your return and you must make the return journey within 14 days of the end of the treatment for which you were repatriated.]

[Includes:

- [Travel costs for the return of [1 – 12] [immediate] family members.]
- [Travel costs for the return of children (under the age of 18).]
- [Travel costs for a companion.]]

[[First class] [Business Class] [Economy class] travel is provided.]

[1]Include when plan provides benefits for companion travel.

We will pay for you [[1]and the person accompanying you] to return to where you were repatriated from. We must approve in advance all arrangements for your return and you must make the return journey within 14 days of the end of the treatment you were repatriated for. We will pay either of the following, whichever is the lesser amount:

- The actual cost you incur for the journey.
- The cost of a scheduled return economy class journey by the most direct route available.]

[4.] [Natural Disaster Evacuation]

[If you require emergency evacuation due to a natural disaster which makes your location uninhabitable, or your specific location in the host country is deemed uninhabitable by us, or our authorized affiliate vendor, we will arrange and pay for evacuation from a safe departure point to the nearest safe location.

[Includes:

- [Evacuation of [1 – 12] [immediate] family members.]

- [Up to [1 - 14] days of [three] [four] [five] star lodging while at a safe haven.]
- [A traveling companion]
- [Evacuation of children (under the age of 18) either to the same location as the Covered Person or to a location where the children can be placed under the care of another guardian or relative.]
- [A per diem for living expenses for [companion] [family members] [children] while member is staying at the safe haven.]

[We will pay for you to return to where you were evacuated from. We must approve in advance all arrangements for your return and you must make the return journey within 14 days of the end of the treatment for which you were repatriated.]

[Includes:

- [Return of [1 – 12] [immediate] family members.]
- [Includes return of children (under the age of 18).]
- [Includes a traveling companion.]

[[First class] [Business Class] [Economy class] travel is provided]]

[5.] [Repatriation of Remains]

[In the event of your death, we or our affiliate or authorized vendor will render assistance and provide for the return of mortal remains. Services include:

- Location of a sending funeral home.
- Transportation of the body from the site of death to the sending funeral home.
- Preparation of the remains for either burial or cremation.
- Transportation of the remains from the funeral home to the airport.
- Minimally necessary casket or air tray for transport.
- Coordination of consular services (in the case of death overseas).
- Procuring death certificates.
- Transport of the remains from the airport to the receiving funeral home.

Other services that may be performed in conjunction with those listed above include making travel arrangements for any traveling companions and identification and/or notification of next-of-kin.

[[Includes:

- [Return of [1 – 12] [immediate] family members] in [First class] [Business Class] [Economy class] travel.]
- [Return of children (under the age of 18) in [First class] [Business Class] [Economy class] travel.]

[6.] [Security Evacuation]

[In the event of an emergency security situation (as defined by us, by the *State Department* or by the country of the event), we will arrange for evacuation from an international airport or other safe departure point to the nearest safe haven. Eligible Expenses are for transportation and related costs to the nearest place of safety necessary to ensure your safety and well-being.

An emergency security situation includes the following:

- Expulsion from a host country or being declared persona non-grata on the written authority of the recognized government of a host country.

- Political or military events involving a host country, if the appropriate authorities issue an advisory stating that citizens of your home country or citizens of the host country should leave the host country.
- Natural disaster within 7 days of an event.]

[Includes:

- [Evacuation of [1 – 12] [immediate] family members.]
- [Up to [1 - 14] days of [three] [four] [five] star lodging while at a safe haven.]
- [A traveling companion.]
- [Evacuation of children (under the age of 18) either to the same location as the Covered Person or to a location where the children can be placed under the care of another guardian or relative.]
- [A per diem for living expenses for [companion] [family members] [children] while member is staying at the safe haven.]

[We will pay for you to return to where you were evacuated from. We must approve in advance all arrangements for your return and you must make the return journey within 14 days of the end of the treatment for which you were repatriated.]

[Includes:

- [Return of [1 – 12] [immediate] family members.]
- [Includes return of children (under the age of 18).]
- [Includes a traveling companion.]

[[First class] [Business class] [Economy class] travel is provided.]

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any service, treatment, item or supply provided within the United States.

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Services, except as may be specifically provided for in *Section 1: Covered Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Service categories described in *Section 1: Covered Services*, those limits are stated in the corresponding Covered Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Services that fall under more than one Covered Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

Include when plan provides benefits for Culturally-Based Services.

[Please note that the following exclusions do not apply to any service, therapy or treatment provided outside the *United States* that is determined to be a Covered Services as described under *Culturally-Based Services* in *Section 1: Covered Services*.]

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Services*.]

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Services*.]

Include when group purchases accidental dental benefit.

3. Dental implants, bone grafts, and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Services*.]
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

Include when the group purchases benefits for speech aid devices and tracheo-esophageal voice devices.

4. Devices and computers to assist in communication and speech [except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Services*].

5. Oral appliances for snoring.

Include when the group purchases benefits for prosthetics and delete variable exclusion #6 further below.

[6.] [Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

Include when the group purchases benefits for prosthetics.

[7.] [Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.]

Include when group does not purchase benefits for prosthetics and delete the variable exclusions #6 and 7 above.

[6.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Services*.]

D. Drugs

[1]Delete when plan provides benefits for Outpatient Prescription Drugs.

1. [[1]Prescription drug products for outpatient use that are filled by a prescription order or refill.]

[2.] Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

[3.] Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

[4.] Over-the-counter drugs and treatments.

[5.] Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.

8. Shoe inserts.

9. Arch supports.

[1]Include when group does not purchase benefits for durable medical equipment.

G. Medical Supplies [[1]and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.
   - Ostomy supplies.

   This exclusion does not apply to:

Include only when group purchases benefits for durable medical equipment.

   - [Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Services*.]

[1]Include only when group purchases benefits for durable medical equipment.

2. Tubings and masks [[1]except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Services*].

Include when group does not purchase benefits for durable medical equipment.

[3.] [Medical equipment of any kind.]

H. Mental Health

1. Services for the treatment of mental illness or mental health conditions.

I. Neurobiological Disorders - Autism Spectrum Disorders

1. Services for the treatment of autism spectrum disorders as the primary diagnosis. (Autism spectrum disorders are a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder,* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.)

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition.

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters, dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
    - Electric scooters.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.
    - Radios.
    - Saunas.
    - Stair lifts and stair glides.
    - Strollers.
    - Safety equipment.
    - Treadmills.
    - Vehicle modifications such as van lifts.
    - Video players.
    - Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.

- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 8 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[M.] [Preexisting Conditions]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.]

[N.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
5. Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy and vision therapy.
6. Psychosurgery.
7. Sex transformation operations.
8. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

11. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

12. Surgical and non-surgical treatment of obesity.

13. Stand-alone multi-disciplinary smoking cessation programs.

14. Breast reduction except as described under *Reconstructive Procedures* in *Section 1: Covered Services.*

[O.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

[1]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

[P.] Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

[4.] The reversal of voluntary sterilization [[1]and voluntary sterilization].

[5.] [[1]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [[1]Contraceptive supplies and services.]

[7.] [[1]Fetal reduction surgery.]

[Q.] Services Provided under another Plan

[1.] Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, *Defense Base Act (DBA)* coverage, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or

mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.
4. Health services provided while you are covered under a separate policy issued through your Enrolling Group as stipulated by a foreign governmental requirement.
5. Health services provided under your primary medical plan.

[R.] Substance Use Disorders

1. Services for the treatment of substance use disorder services.

[S.] Transplants

1. Health services for organ and tissue transplants.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person.

[T.] Travel

[1]Include when plan provides benefits for any service described in Section 1 for emergency evacuation, medical repatriation, repatriation of remains or security evacuation. Include and select the services that are covered. Include "and" and "comma" appropriately.

1. Travel or transportation expenses, even though prescribed by a Physician. [[1]This exclusion does not apply to [*Emergency Evacuation*] [,] [and] [*Medical Repatriation*] [,] [and] [*Natural Disaster Evacuation*][,] [and] [*Repatriation of Remains*] [,] [and] [*Security Evacuation*] for which Benefits are described under *Evacuation and Repatriation Benefits* in *Section 1: Covered Services*.]

[U.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
9. Home health care.
10. Hospice care.
11. Preventive medical care.

[V.] Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

[2.] Routine vision examinations, including refractive examinations to determine the need for vision correction.

[3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

[4.] Eye exercise or vision therapy.

[5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

[6.] Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

[W.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Service - see the definition in *Section 8: Defined Terms*.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

[1]Delete when Benefits are provided for immunizations for travel.

[2]Delete when Benefits are provided for immunizations for career and employment.

- Required solely for purposes of school, sports or camp [[1], travel,] [[2]career or employment,] insurance, marriage or adoption.
- Related to judicial or administrative proceedings or orders.
- Conducted for purposes of medical research.
- Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Subscribers who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.

5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

6. In the event a provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

9. Autopsy.

10. Sign language [and foreign language] services.

Include and complete when the Enrolling Group chooses to exclude coverage by country or geographic region.

[11.] [Health services provided in the following [countries] [geographic regions]:

- [North Korea.]
- [Cuba.]
- [_____.]]

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [[1]both Medicare Part A and Part B] [[2]Medicare Part A, Part B and Part D] [[3]Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 8: Defined Terms*.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Include Open Enrollment Period unless a group chooses a closed plan.

[Open Enrollment Period]

[The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

New Eligible Persons

Coverage for a new Eligible Person begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

Throughout this section, select appropriate option for "date" or "last day of the calendar month in which" and delete the other.

- **You Are No Longer Eligible**

  Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Eligible Person" and "Subscriber".

- **We Receive Notice to End Coverage**

  Your coverage ends on the [date][last day of the calendar month in which] we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

  Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

  This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information.

  During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under

the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

[Extended Coverage for Evacuation and Repatriation Benefits If You Are an Inpatient]

[If you are an inpatient in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility at the time coverage under the Policy would otherwise end, as described above, your Evacuation and Repatriation Benefits will be temporarily extended. Benefits will be extended only for the treatment of the condition that has caused the Inpatient Stay. Benefits will be paid until the earlier of either of the following:

- Thirty (30) days from the date of the event that triggered the need for Evacuation and/or Repatriation.
- The date you are discharged from the Inpatient Stay.
- The date you reach any maximum Benefit limit that applies.
- The date your Physician determines that the Inpatient Stay is no longer necessary or appropriate.

These extended Benefits are subject to all terms, conditions, limitations and exclusions of the Policy that is in effect on the day immediately prior to the date coverage would otherwise end.]

Section 5: How to File a Claim

Requesting Payment

You are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology (CPT)* codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

  The above information should be filed with us at the address on your ID card.

Payment of Benefits

We make all payments directly to you. [In our discretion, payment will be made in one of the following ways:

- In the currency of the invoices relating to the claim.
- In *U.S.* dollars.
- In the currency of your choice.]

It is your responsibility to pay any charges which are not eligible for payment under the Policy.

[How Exchange Rates will be Calculated]

[If it is necessary to make a conversion from one currency to another, we will use the mid-market exchange rate in effect on the date of service.]

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior notification or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request

and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

If you are dissatisfied with the resolution reached through the Company's internal grievance system regarding Medical Necessity, you may contact the Director of the Department of Health at the following:

Attention: [Grievance Coordinator
District of Columbia Department of Health
Office of the General Counsel
Grievance and Appeals Coordinator
825 North Capitol Street, NE, Room 4119
Washington, DC 20002
(202) 442-5979]

If you are dissatisfied with the resolution reached through the Company's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

Commissioner
Department of Insurance, Securities and Banking
[810 First Street, NE
Suite 701
Washington, DC 20002
(202) 727-8000]

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Enrolling Groups are solely contractual relationships between independent contractors. Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.

- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Service.
- You must decide if any provider treating you is right for you. This includes providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

[1]Include when rebates are passed on to Subscribers. [2]Include when rebates are not passed on to Subscribers.

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We [[1]do] [[2]do not] pass these rebates on to you, [[1]and they are applied to any Annual Deductible and] [[2]nor are they applied to any Annual Deductible or] taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Subscribers. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Subscribers

In the event of a question or dispute regarding your right to Benefits, we may require that a Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Defense Base Act (DBA) Coverage not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by the *Defense Base Act*.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners, your primary medical plan or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.

- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Subscriber, that Subscriber, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Subscriber or did not legally have to be paid by the Subscriber.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Subscriber agrees to help us get the refund when requested.

If the Subscriber, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Subscriber that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Annual Maximum Benefit - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.

Benefits - your right to payment for Covered Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Services.

Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.

- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Services.

Please note that for Covered Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Person - the Subscriber, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Covered Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of diagnosing or treating a Sickness, Injury, mental illness, substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Subscriber, Physician, facility or any other person.
- Described in this *Certificate* under *Section 1: Covered Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Subscribers on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Domestic Partner - an unmarried opposite or same sex adult who resides with the Subscriber and who has registered in a state or local domestic partner registry with the Subscriber. Each partner must: (1) be at least 18 years old and competent to contract; and (2) be the sole domestic partner of the other person.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Services, incurred while the Policy is in effect, Eligible Expenses are determined by us, at our discretion, based on the following:

- Any applicable contracted or negotiated fee(s) with the provider.
- If the fees are not contracted or negotiated with the provider, then the Eligible Expenses will be representative of the average and prevailing charge for the same health service in the same or similar geographic communities where the Covered Service is rendered.
- In all circumstances, the charges shall not exceed the fees that the provider would charge any other party for the same health service.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or mental illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- When medical, surgical, diagnostic, psychiatric, substance use disorder and other health care services, technologies, supplies, treatments, procedures, drug therapies, medications and devices are provided outside the *United States*, the determination of status as an Experimental or Investigational Service will be made in our reasonable judgment based on clinical standards that apply within the country in which the service is provided and relevant regulatory review processes and requirements.
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

  For services provided outside the *United States*, if the service is one that requires review and approval by a governmental agency, then the service must be approved by that agency.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Medically Necessary - health care services provided for the purpose of evaluating, diagnosing or treating a Sickness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, mental illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Per Trip Deductible - for Benefit plans that have a Per Trip Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Per Trip Deductible is calculated on the basis of Eligible Expenses. The Per Trip Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Trip Deductible and for details about how the Annual Deductible applies.

Per Trip Out-of-Pocket Maximum - for Benefit plans that have a Per Trip Out-of-Pocket Maximum, this is the maximum amount you pay for Benefits during a single trip. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Per Trip Out-of-Pocket Maximum and for details about how the Per Trip Out-of-Pocket Maximum applies.

Pharmaceutical Product(s) - prescription pharmaceutical products that are reviewed and approved by the applicable governmental agency and administered in connection with a Covered Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers enrolled under the Policy.

Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [three] [six] [twelve] month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber, in accordance with the terms of the Policy.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a home health agency on a per visit basis for a specific purpose.
- The service is provided to a Subscriber by an independent nurse who is hired directly by the Subscriber or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Rider - any attached written description of additional Covered Services not described in this *Certificate*. Covered Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Service, the difference in cost between a Semi-private Room and a private room is a Benefit

only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include mental illness or substance use disorders, regardless of the cause or origin of the mental illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com].

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Service for a Subscriber with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
    - For services provided outside the *United States*, if the service is one that requires review and approval by a governmental agency, then the service must be approved by that agency.
    - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
    - The Subscriber must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
    - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.

The decision about whether such a service can be deemed a Covered Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UnitedHealthcare [Name of Product]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Supplemental Benefits

[1]Include only if Policy is issued to support business travel and select "primarily", "solely" or "for the purpose of business" as applicable.

Supplemental Benefits are payable for Covered Services that are provided by or under the direction of a Physician or other provider. Benefits are available only for Covered Services received by a Subscriber who is traveling outside [his or her home country] [the *United States*] [[1][solely] [primarily] [for the purpose of business], as authorized by the Enrolling Group]. [Benefits are also available during sojourn travel [for the Subscriber and [1 - 12] dependent[s], which is leisure travel in conjunction with the original trip. This extended travel can take place before, during or after the original trip. Benefits for sojourn travel are limited to [2 - 90] days.]

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Benefits

Include only when an Annual Deductible applies. Do not include when a per-trip deductible applies.

[Annual Deductibles are calculated on a [calendar] [Policy] year basis.]

Include only when the standard Out-of-Pocket Maximum applies. Do not include when a per-trip Out-of-Pocket Maximum applies.

[Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

Include only when an Annual Maximum Benefit applies.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Always include except when limits do not apply for any service.

[Benefit limits are calculated on a [calendar] [Policy] year basis unless otherwise specifically stated.]

Payment Term And Description	**Amounts**
Include only when an annual deductible applies. **[Annual Deductible]**	
[The amount of Eligible Expenses you pay for Covered Services per year before you are eligible to receive Benefits.] *Include when day/visit limits are reduced by the number of days/visit used toward meeting the deductible.* [Amounts paid toward the Annual Deductible for Covered Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.] *Include when dollar limits are reduced by the amount used*	*Include when separate individual and family deductibles apply (non-embedded).* [For single coverage, the Annual Deductible is $[0 - 30,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family

toward meeting the deductible. [Amounts paid toward the Annual Deductible for Covered Services that are subject to a dollar limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the amount used toward meeting the Annual Deductible.] *Include when the carry-over provision applies.* [Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.] *Include paragraph if the roll-over provision applies to a group in any circumstance.* [When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.] *Include paragraph if the roll-over provision applies to a group changing from a calendar year to Policy year plan. [1]Include when this applies only to the individual deductible.* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Annual Deductible.]] [The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.] *Include only when a per occurrence deductible applies.* [The Annual Deductible does not include any applicable Per Occurrence Deductible.]	coverage, the family Annual Deductible is $[0 - 90,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.] *Include when individual deductible applies (embedded).* [$[0 - 30,000] per Covered Person.] *Include when individual (with family maximum) deductible applies (embedded).* [$[0 - 30,000] per Covered Person, not to exceed $[0 - 90,000] for all Covered Persons in a family.] [For any combination of **Medical Benefits** and **Evacuation and Repatriation Benefits**: [$[0 - 30,000] per Covered Person.] [$[0 - 30,000] per Covered Person, not to exceed $[0 - 90,000] for all Covered Persons in a family.] [For **Evacuation and Repatriation Benefits**: [$[0 - 30,000] per Covered Person.] [$[0 - 30,000] per Covered Person, not to exceed $[0 - 90,000] for all Covered Persons in a family. [For **Medical Benefits**: [$[0 - 30,000] per Covered Person.] [$[0 - 30,000] per Covered Person, not to exceed $[0 - 90,000] for all Covered Persons in a family.]
Include only when a per trip deductible applies. **[Per Trip Deductible]**	
[The amount of Eligible Expenses you pay for Covered Services per trip before you are eligible to receive Benefits. A "trip" is defined as Enrolling Group sponsored travel by land, air or sea from the time the Covered Person leaves his or her own country until the time of return to the home country A "trip" also includes sojourn travel, when Benefits are available under the Policy.]	[For any combination of **Medical Benefits** and **Evacuation and Repatriation Benefits**: [$[0 - 30,000] per Covered Person.] [$[0 - 30,000] per Covered Person, not to exceed $[0 - 90,000] for all Covered Persons in a family.] [For **Evacuation and Repatriation**

	Benefits: [$[0 - 30,000] per Covered Person.] [$[0 - 30,000] per Covered Person, not to exceed $[0 - 90,000] for all Covered Persons in a family. [For **Medical Benefits**: [$[0 - 30,000] per Covered Person.] [$[0 - 30,000] per Covered Person, not to exceed $[0 - 90,000] for all Covered Persons in a family.]
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	*Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.]
Include only when an annual out-of-pocket maximum applies. **[Out-of-Pocket Maximum]**	
[1]Include when OOPM includes the Annual Deductible. *[2]Include when OOPM includes the Per Occurrence Deductible.* *[3]Include when OOPM includes Copayments.* [The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. *[5]Include only when the plan design does not apply all Copayments/Coinsurance to the OOPM.* [[5]Copayments and Coinsurance for some Covered Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which	*Include when separate individual and family maximums apply (non-embedded).* [For single coverage, the Out-of-Pocket Maximum is $[0 - 90,000] per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $[0 - 270,000].] *Include when individual OOPM applies (embedded).*

Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following: • Any charges for non-Covered Services. *Include bullet if notification requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.* • [The amount Benefits are reduced if you do not notify us as required.] • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.]	[$[0 - 90,000] per Covered Person.] *Include when individual (with family maximum) applies (embedded).* [$[0 - 45,000] per Covered Person, not to exceed $[0 - 270,000] for all Covered Persons in a family.] [For any combination of **Medical Benefits** and **Evacuation and Repatriation Benefits**: [$[0 - 90,000] per Covered Person.] [$[0 - 90,000] per Covered Person, not to exceed $[0 - 180,000] for all Covered Persons in a family.] [For **Evacuation and Repatriation Benefits**: [$[0 - 90,000] per Covered Person.] [$[0 - 90,000] per Covered Person, not to exceed $[0 - 180,000] for all Covered Persons in a family. [For **Medical Benefits**: [$[0 - 90,000] per Covered Person.] [$[0 - 90,000] per Covered Person, not to exceed $[0 - 180,000] for all Covered Persons in a family.] *Include when the OOPM includes the Annual Deductible.* [The Out-of-Pocket Maximum includes the Annual Deductible.] *Include when the OOPM does not include the Annual Deductible.* [The Out-of-Pocket Maximum does not include the Annual Deductible.] *Include when the OOPM includes the Per Occurrence Deductible.* [The Out-of-Pocket Maximum includes the Per Occurrence Deductible.] *Include when the OOPM does not include the Per Occurrence Deductible.* [The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]

Include only when the OOPM applies per trip rather than per year.

[Per Trip Out-of-Pocket Maximum]

[1]Include when OOPM includes the Annual Deductible.

[2]Include when OOPM includes the Per Occurrence Deductible.

[3]Include when OOPM includes Copayments.

[The maximum you pay per trip for [[1]the Per Trip Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Per Trip Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. A "trip" is defined as Enrolling Group sponsored travel by land, air or sea from the time the Covered Person leaves his or her own country until the time of return to the home country A "trip" also includes sojourn travel, when Benefits are available under the Policy.]

[5]Include only when the plan design does not apply all Copayments/Coinsurance to the OOPM.

[[5]Copayments and Coinsurance for some Covered Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:

- Any charges for non-Covered Services.

Include bullet if notification requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.

- [The amount Benefits are reduced if you do not notify us as required.]
- Charges that exceed Eligible Expenses.
- Copayments or Coinsurance for any Covered Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.]

[For any combination of **Medical Benefits** and **Evacuation and Repatriation Benefits**: [$[0 - 90,000] per Covered Person.] [$[0 - 180,000] per Covered Person, not to exceed $[0 - 180,000] for all Covered Persons in a family.]

[For **Evacuation and Repatriation Benefits**: [$[0 - 90,000] per Covered Person.] [$[0 - 90,000] per Covered Person, not to exceed $[0 - 180,000] for all Covered Persons in a family. [For **Medical Benefits**: [$[0 - 90,000] per Covered Person.] [$[0 - 90,000] per Covered Person, not to exceed $[0 - 180,000] for all Covered Persons in a family.]

Include when the OOPM includes the Per Trip Deductible.

[The Per Trip Out-of-Pocket Maximum includes the Per Trip Deductible.]

Include when the OOPM does not include the Per Trip Deductible.

[The Per Trip Out-of-Pocket Maximum does not include the Per Trip Deductible.]

Include when the OOPM includes the Per Occurrence Deductible.

[The Per Trip Out-of-Pocket Maximum includes the Per Occurrence Deductible.]

Include when the Per Trip OOPM does not include the Per Occurrence Deductible.

[The Per Trip Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]

Include only when a Maximum Policy Benefit applies. **[Maximum Policy Benefit]**	
[The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.]	[For any combination of **Medical Benefits** and **Evacuation and Repatriation Benefits**: $[1,000 - 30,000,000] per Covered Person.] [For **Medical Benefits**: $[1,000 - 30,000,000] per Covered Person.] [For **Evacuation and Repatriation Benefits**: $[1,000 - 30,000,000] per Covered Person.] [No Maximum Policy Benefit.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	
[The maximum amount we will pay for Benefits during the year.]	[For any combination of **Medical Benefits** and **Evacuation and Repatriation Benefits**: $[1,000 - 30,000,000] per Covered Person.] [For **Medical Benefits**: $[1,000 - 30,000,000] per Covered Person.] [For **Evacuation and Repatriation Benefits**: $[1,000 - 30,000,000] per Covered Person.]
Include only when a per trip maximum benefit applies. **[Per Trip Maximum Benefit]**	
[The maximum amount we will pay for Benefits during a single trip. A "trip" is defined as Enrolling Group sponsored travel by land, air or sea from the time the Covered Person leaves his or her own country until the time of return to the home country A "trip" also includes sojourn travel, when Benefits are available under the Policy.]	[For any combination of **Medical Benefits** and **Evacuation and Repatriation Benefits**: $[1,000 - 30,000,000] per Covered Person.] [For **Medical Benefits**: $[1,000 - 30,000,000] per Covered Person.] [For **Evacuation and Repatriation Benefits**: $[1,000 - 30,000,000] per Covered Person.]
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Service. Please note that for Covered Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of*	

Benefits table.
Coinsurance
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Medical Benefits

Covered Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the [Per Trip] Out-of-Pocket Maximum?**	**Must You Meet [Annual] [Per Trip] Deductible?**
[1.] Ambulance Services			
Pre-service Notification Requirement [1]*Include when Benefits for Emergency Evacuation are sold.* In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify us as soon as possible prior to transport. [[1]Please note that Benefits under this section do not include emergency evacuation. See *Emergency Evacuation* described below under *Evacuation and Repatriation Benefits*.]			
Emergency Ambulance *Include the limit selected by the group.* [Ground ambulance limited to $[500 - 10,000] per year.] *Include the limit selected by the group.* [Air ambulance limited to $[1,000 - 20,000] per year.]	*Ground Ambulance:* [50 - 100]% *Air Ambulance:* [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* [50 - 100]% *Air Ambulance:* [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[2.] [Culturally-Based Services]			
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
Include for groups that purchase benefits for dental pain relief. **[3.] [Dental Pain Relief]**			
[Limited to $[50 - 2,500] per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the [Per Trip] Out-of-Pocket Maximum?**	**Must You Meet [Annual] [Per Trip] Deductible?**
Include for groups that purchase benefits for accident-related dental services. **[4.] [Dental Services - Accident Only]**			
[Limited to $[1,000 - 5,000] per year. [Benefits are further limited to a maximum of $[500 - 2,500] per tooth.]]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
Include for groups that purchase benefits for DME. **[5.] [Durable Medical Equipment]**			
Include the limit selected by the group. *[1]Include either option as standard plan design.* [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[500 - 10,000] in Eligible Expenses for Tier 1.Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [$[25,001 - 100,000] in Eligible Expenses for Tier 3.] These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] *[1]Include when Benefits are provided for speech aid and tracheo-esophageal voice devices.* *[2]Include when devices are not included in the annual DME limit.* [[1]Benefits for speech aid devices and tracheo-esophageal voice devices are	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the [Per Trip] Out-of-Pocket Maximum?**	**Must You Meet [Annual] [Per Trip] Deductible?**
limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [[2]not] included in the annual limits stated above.]			
[6.] Emergency Health Services - Outpatient			
Include when benefit is limited. [Limited to $[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
[7.] Hospital - Inpatient Stay			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
[8.] Lab, X-Ray and Diagnostics - Outpatient			
Include limit selected by group. [Limited to $[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
[9.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
Include limit selected by group. [Limited to $[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
Include when outpatient prescription drugs are covered under the medical plan. **[10.] [Outpatient Prescription Drugs]**			
	[[50 - 100]%] [100% after you pay a Copayment of $[1 - 200] per prescription order or refill]	[Yes] [No]	[Yes] [No]
[11.] Pharmaceutical Products - Outpatient			
Include limit selected by group.	[[50 - 100]%]		

Covered Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the [Per Trip] Out-of-Pocket Maximum?**	**Must You Meet [Annual] [Per Trip] Deductible?**
[Limited to $[100 - 5,000] per year.]	*Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	[Yes] [No] [Yes, except when provided during a Physician office visit]	[Yes] [No] [Yes, except when provided during a Physician office visit]
[12.] Physician Fees for Surgical and Medical Services			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[13.] Physician's Office Services - Sickness and Injury			
Include if group chooses to limit benefit. [1]Insert limit selected by group. [Limited to [[1]2 - 10] visits per year.]	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

Covered Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the [Per Trip] Out-of-Pocket Maximum?	Must You Meet [Annual] [Per Trip] Deductible?
	subsequent visits in that year] [100% after you pay a Copayment of $[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [100% after you pay a Copayment of $[5 - 75] per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]		
[1]Include when group purchases Benefits for Maternity Services. *[2]Include when group purchases Benefits for Complications of Pregnancy only.* **[14.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]**			
	[1]Include when benefits are provided for maternity services. *[3]Include when an annual deductible applies.* *[4]Include when services in the Physician's office are subject to a Copayment.* [[1]Benefits will be the same as those stated under each Covered Service category in this *Schedule of Benefits* [[3]except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [[4]For Covered Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] *[2]Include when benefits are provided for complications of pregnancy only.* [[2]Benefits will be the same as those stated under each Covered Service category in this *Schedule of Benefits*.]		
Include when group purchases			

Covered Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the [Per Trip] Out-of-Pocket Maximum?	Must You Meet [Annual] [Per Trip] Deductible?
benefits for prosthetic devices. **[15.] [Prosthetic Devices]**			
Include the limit selected by the group. *[1]Include either option as standard.* [[1]Limited to $[2,500 - 100,000] per year. Benefits are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years].] [[1]Limited per year as follows: • A maximum of $[10,000 - 30,000] per body part for each arm, leg, hand or foot. • A maximum of $[5,000 - 15,000] per body part for each eye, ear, nose, face or breast. These limits include repair. Benefits for replacement are limited to a single purchase of each type of prosthetic device every [year] [[two-five] years]. *Always include statement below except when prosthetics are not limited.* [Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[16.] Reconstructive Procedures			
	Depending upon where the Covered Service is provided, Benefits will be the same as those stated under each Covered Service category in this *Schedule of Benefits*. *Include when group does not purchase benefits for prosthetic devices.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		

Covered Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	**Apply to the [Per Trip] Out-of-Pocket Maximum?**	**Must You Meet [Annual] [Per Trip] Deductible?**
[17.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[18.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Include limit selected by group. [Limited to [40 - 180] days per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
[19.] Surgery - Outpatient			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
[20.] Therapeutic Treatments - Outpatient			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[21.] Urgent Care Center Services			
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]

Evacuation and Repatriation Benefits

[1.] [Emergency Medical Evacuation]	
Include when pre-service notification is required. *[1]Include when non-notification penalty applies.* *[2]Include and insert applicable reduction in Benefits if benefit reduction applies.* *[3]Include when Benefits will not be paid.*	
[Pre-service Notification Requirement] [You must notify us as soon as the possibility of Emergency Evacuation arises. [1]If you don't notify us, [2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [3]you will be responsible for paying all	

charges and no Benefits will be paid].]			
[Limited to [$1,000 - $500,000] per Covered Person per [year] [trip].]	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
[2.] [Emergency Family Reunion]			
Include when pre-service notification is required. *[1]Include when non-notification penalty applies.* *[2]Include and insert applicable reduction in Benefits if benefit reduction applies.* *[3]Include when Benefits will not be paid.* **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility for Emergency Family Reunion Benefits arises. [1]If you don't notify us, [2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [3]you will be responsible for paying all charges and no Benefits will be paid].]			
[A per diem for living expenses for [companion] [[1 - 12] family members] [children] of [$1 - $5,000] while member is hospitalized up to [1 – 60 days.] [Benefits are limited to $[1,000 - 500,000] per person.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[3.] [Medical Repatriation]			
Include when pre-service notification is required. *[1]Include when non-notification penalty applies.* *[2]Include and insert applicable reduction in Benefits if benefit reduction applies.* *[3]Include when Benefits will not be paid.* **[Pre-service Notification Requirement]** [You must notify us to obtain Benefits for Medical Repatriation. [1]If you don't notify us, [2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [3]you will be responsible for paying all charges and no Benefits will be paid].]]			
[Benefits are provided for an allowance of up to $[1 - 5,000] per day for up to [one - ten] [11 - 60] day[s] towards the living expenses incurred	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport]	[Yes] [No]	[Yes] [No]

by the person(s) accompanying you.]	[100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]		
	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
[4.] [Natural Disaster Evacuation]			

Include when pre-service notification is required.

[1]*Include when non-notification penalty applies.*

[2]*Include and insert applicable reduction in Benefits if benefit reduction applies.*

[3]*Include when Benefits will not be paid.*

[Pre-service Notification Requirement]

[You must notify us to obtain Benefits for Natural Disaster Evacuation. [[1]If you don't notify us, [[2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[3]you will be responsible for paying all charges and no Benefits will be paid].]]

[Benefits are limited to $[1,000 - 500,000] per person.] [Benefits are provided for an allowance of up to $[1 - 5,000] per day for up to [one - ten] [11 - 60] day[s] towards the living expenses incurred while at the safe haven.]	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]

Include when benefits are provided for Repatriation of Remains.

[5.] [Repatriation of Remains]

Include when pre-service notification is required.

[1]Include when non-notification penalty applies.

[2]Include and insert applicable reduction in Benefits if benefit reduction applies.

[3]Include when Benefits will not be paid.

[Pre-service Notification Requirement]

[You must notify us to obtain Benefits for Repatriation of Remains. [[1]If you don't notify us, [[2]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[3]you will be responsible for paying all charges and no Benefits will be paid].]]

[Benefits are limited to $[1,000 - 500,000] per person.]	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes][No]	[Yes][No]

[6.] [Security Evacuation]

Include when pre-service notification is required.

[1]Include when non-notification penalty applies.

[2]Include and insert applicable reduction in Benefits if benefit reduction applies.

[3]Include when Benefits will not be paid.

[Pre-service Notification Requirement]

[You must notify us as soon as the possibility of a security evacuation arises. [[1]If you don't notify us, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses].]

[Benefits are limited to $[1,000 - 500,000] per person.] [Benefits are provided for an allowance of up to $[1 - 5,000] per day for up to [one - ten] [11 - 60] day[s] towards the living expenses incurred while at the safe haven.]	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. You are responsible for paying, directly to the provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

Accidental Death and Dismemberment Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides benefits for accidental death and dismemberment, as described below.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 8: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to [Name of Entity]. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 8: Defined Terms*.

_____

(Name and Title)

Benefits for Accidental Death and Dismemberment

If the Covered Person suffers a loss described below, we will pay the amount of insurance that applies. The Covered Person or Covered Person's beneficiary, must give us proof of all of the following:

- Injury occurred while the insurance was in force under this section.
- Loss occurred within 90 days after the Injury.
- Loss was due to Injury independent of all other causes.

Amount of Insurance: $[_____] will be paid according to the following table:

Include conditions in table and explanations directly below according to plan design.

[Loss of life]	[100%]
[Loss of both hands or both feet]	[50%]
[Loss of sight of both eyes]	[50%]
[Loss of one hand and sight of one eye]	[50%]
[Loss of one foot and sight of one eye]	[50%]
[Quadriplegia]	[25%]
[Paraplegia]	[25%]
[Triplegia]	[25%]
[Loss of one hand]	[25%]
[Loss of one foot]	[25%]
[Loss of sight of one eye]	[25%]
[Coma]	[25%]
[Loss of speech]	[25%]
[Loss of hearing]	[25%]
[Hemiplegia]	[25%]
[Uniplegia]	[25%]
[Loss of thumb and index finger of the same hand]	[25%]

[Loss of sight means total and irrecoverable loss of sight.] [Loss of hands or feet means severance at or above the wrist or ankle.] [Loss of thumb and index finger means the actual, complete and permanent severance through or above the metacarpophalangeal joints.] [Loss of speech means the total and irrecoverable loss of speech.] [Loss of hearing means total and irrecoverable loss of hearing.] [Quadriplegia means total and permanent paralysis of both upper and lower limbs.] [Paraplegia means total and permanent paralysis of both lower limbs.] [Uniplegia means the total and permanent paralysis of one limb.] [Triplegia means the total and permanent paralysis of three limbs.] [Hemiplegia means total and permanent paralysis of upper and lower limbs on one side of the body.] [Paralysis means permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity.] [Paralysis must be the result of an Injury to the brain or spinal cord and without the severance of a limb.] [Coma means the diagnosis of a state of unconsciousness for a continuous period of at least 90 days.]

In paying this benefit, we will consider only losses sustained while insured under this Rider. We will pay no more than the full amount shown above for losses resulting from any one Injury.

Limitations: We will not pay a benefit under this Rider for a loss caused directly or indirectly by any of the following:

- Disease, bodily or mental infirmity, or medical or surgical treatment of these.
- Suicide or intentionally self-inflicted Injury, while sane or insane.

- Participation in a riot or insurrection, or commission of an assault or felony.
- War or any act of war, declared or undeclared.
- Use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician.
- Driving while intoxicated, as defined by the applicable state law where the loss occurred.
- [Engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping or using off-road vehicles.]
- [Injury arising out of or in the course of any occupation or employment for pay or profit, or any] [Any] Injury or Sickness for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law.
- [Travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on either a scheduled route or a charter flight seating 15 or more people.]
- [Travel or flight in, or descent from any aircraft, except if employment duties require the Covered Person to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on either a scheduled route or a charter flight seating 15 or more people.]

Notice of Claim: Written notice of a claim for death or Injury must be given to us at our home office by the Covered Person or his beneficiary within [30 - 90] days of the date of death or the date the Injury occurred. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's Enrolling Group, or can requested from us. If the Covered Person does not receive the form from us within [15 - 30] days of his or her request, written proof of claim should be sent to us without waiting for the form. Written proof should establish facts about the claim such as date of occurrence, nature, and extent of the loss involved.

Proof of Claim: Written proof of claim must be filed within 90 days of the loss. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

[**Physical Examination and Autopsy:** We have the right to have a Physician of our choice examine the Covered Person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.]

Insured Business Travel Employer Application

UnitedHealthcare Global

UnitedHealthcare Insurance Company
450 Columbus Avenue
Hartford, CT 06115

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. Include a check in the amount of any required annual premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

General Information

Requested Effective Date (mm/dd/yyyy) _____ / _____ / _____

Group's/Company's Legal Name

Street Address			Tax ID	
City		State	Zip Code	County
Contact Person	Telephone	Fax	Email Address	
Billing Address (if different)			# of Years in Business	
Multi-location group/company? ☐ Yes ☐ No	# of Locations	Address(es) (or list on additional sheet of paper)		
Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other _____		Nature of Business	Industry Code	
Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owner				

Participation

☐ # Subscribers Applying for
☐ # of Travelers
☐ # of Weeks of Travel
☐ Total # Subscribers

Business Travel Medical	
Business Travel AD&D	
Dependent Travel included	
Sojourn Travel (up to 7 days)	
Other	

General Information (Continued)

☐ Yes ☐ No In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

☐ Yes ☐ No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be place voluntarily into bankruptcy?

☐ Yes ☐ No Is your group a Professional Employer Organization (PEO) or Subscriber Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site subscriber(s)?

If you answered Yes, then by signing this application you agree with the certification in this section.

I hereby certify that my company is a PEO, ELC or other such entity and that only those subscribers that are the corporate subscribers of my company, and not my co-subscribers, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-subscribers under the group's plan, I understand that UnitedHealthcare will not cover the co-subscribers under this group policy.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an subscriber begins a leave of absence? ☐ Yes ☐ No
(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an subscriber is on leave.)

Coverage provided by "UnitedHealthcare and Affiliates":
Supplemental coverage provided by UnitedHealthcare Insurance Company

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of subscribers or their dependents, including the addition of any newly eligible subscribers or dependents. Prior to receiving notification of approval, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible subscriber or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of subscribers and their dependents in providing coverage under the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any subscribers and dependents who have elected continuation of insurance benefits. I understand that material omissions, misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's subscribers.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject the individual to criminal and civil penalties.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:
*We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of subscribers. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance.

For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature (Form must be signed)

Group/Company Signature _____ Date (mm/dd/yyyy) ____ / ____ / _____ Title_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Broker Information

I hereby certify that I have truly and accurately recorded information supplied by the insured on this form

Signature _____

Broker Name	Agency	Agent Code/Tax ID Number

Email Address	Social Security #	Phone Number	Date

Broker Commission Schedule _____ %

For internal use only

Rep Name	Rep #

Insured Employer Application

UnitedHealthcare Global

UnitedHealthcare Insurance Company
450 Columbus Avenue
Hartford, CT 06115

To avoid processing delays, please make sure you:
1. Answer all questions completely and accurately.
2. DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.
3. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

General Information

Requested Effective Date (mm/dd/yyyy) _____ / _____ / _____

Group's/Company's Legal Name

Street Address			Tax ID	
City		State	Zip Code	County
Contact Person	Telephone	Fax	Email Address	
Billing Address (if different)			# of Years in Business	

Multi-location group/company? ☐ Yes ☐ No	# of Locations	Address(es) (or list on additional sheet of paper)

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other _____	Nature of Business	Industry Code

Waiting Period for new hires ☐ 1st of Policy Month following Date of Hire ☐ 1st of Policy Month following ___ [months] [days] of employment ☐ Date of Hire (no waiting period) ☐ ____ [months] [days] of employment following Date of Hire ☐ Other _____	Waiting Period waived for initial enrollees ☐ Yes ☐ No	Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year	ERISA Plan? ☐ Yes ☐ No

Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (subscribers/dependents)	Number of Subscribers Termed in last 12 Months	Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Name of Workers' Compensation Carrier	Names of Owners/Partners not covered by Workers' Compensation

☐ By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation		# Subscribers Applying for:		# Subscribers Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Subscribers		Medical		Medical		Medical		
# Ineligible Subscribers		Dental		Dental		Dental		
Total # Subscribers		Vision		Vision		Vision		
		Basic EE Life/AD&D		Basic EE Life/AD&D		Basic EE Life/AD&D		
		Basic Dep Life		Basic Dep Life		Basic Dep Life		
# Hours per week to be eligible* *		Supp EE Life/AD&D		Supp EE Life/AD&D		Supp EE Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
# of weeks of Travel		Business Travel Medical		Business Travel Medical		Business Travel Medical		
# of Travelers		Travel AD&D		Travel AD&D		Travel AD&D		
* *For Disability products the minimum # of work hours per week to be eligible is 30 hours.		LTD		LTD		LTD		
		Other		Other		Other		

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company
Dental coverage provided by UnitedHealthcare Insurance Company
Life and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

General Information (continued)

☐ Yes ☐ No In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

☐ Yes ☐ No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be place voluntarily into bankruptcy?

☐ Yes ☐ No Is your group a Professional Employer Organization (PEO) or Subscriber Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site subscriber(s)?

If you answered Yes, then by signing this application you agree with the certification in this section.

I hereby certify that my company is a PEO, ELC or other such entity and that only those subscribers that are the corporate subscribers of my company, and not my co-subscribers, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-subscribers under the group's plan, I understand that UnitedHealthcare will not cover the co-subscribers under this group policy.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an subscriber begins a leave of absence? ☐ Yes ☐ No
(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an subscriber is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)

☐ 3 Months (following the last day worked for the minimum hours required to be eligible)

☐ 6 Months (following the last day worked for the minimum hours required to be eligible)

☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for:
(1) No longer than 3 consecutive months if the subscriber is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the subscriber is totally disabled.

If this coverage terminates, the subscriber may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Business Travel Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Long-Term Disability Carrier	☐ None			

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of subscribers or their dependents, including the addition of any newly eligible subscribers or dependents. Prior to receiving notification of approval, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible subscriber or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of subscribers and their dependents in providing coverage under the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any subscribers and dependents who have elected continuation of insurance benefits. I understand that material omissions, misrepresentations or misstatements in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's subscribers.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject the individual to criminal and civil penalties.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:
*We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of subscribers. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and click on the drop down box for employers under "View Our Programs – Producer Payment Programs." For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature (Form must be signed)

Group/Company Signature _____ Date (mm/dd/yyyy) ____ / ____ / _____ Title_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Broker Information

I hereby certify that I have truly and accurately recorded information supplied by the insured on this form

Signature _____

Broker Name	Agency	Agent Code/Tax ID Number	
Email Address	Social Security #	Phone Number	Date

Broker Commission _____ %

For internal use only

Rep Name	Rep #

Enrollment Application/ Change/Cancellation Request

UnitedHealthcare Global

P.O. Box 740111, Atlanta, GA 30374-0111
Fax: 877-370-4150

☐ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change____ /___ /____ (mm/dd/yyyy)

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the subscriber completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the subscriber is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation Medical _____ Vision _____
Dental _____ Life _____ AD&D _____ LTD _____

Reporting Code Medical _____ Vision _____
Dental _____ Life _____ AD&D _____ LTD _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___ /___ /___ (mm/dd/yyyy)
If non-U.S. Citizen - Subscriber Number _____
Requested Date of Coverage ___ /___ /___ (mm/dd/yyyy)
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date_____
☐ **Annual Open Enrollment**
Requested Effective Date of Enrollment ___ /__ /___ (mm/dd/yyyy)

☐ **Cancellations:** Last Date of Employment ___ /___ /___
mm dd yyyy
Requested Effective Date of Cancellation ___ /___ /___
mm dd yyyy
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Subscriber Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Signature	Date
Employer Position	Phone

A. Subscriber Information

Social Security Number (US only)	Birthdate / / mm dd yyyy	Sex ☐ M ☐ F	Last Name	First Name	MI

Assignment Residence Address Apt# City/Town State/Region Area Postal Code Country

Home Phone Work Phone Cell Phone

Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other–Please specify
*Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Preferred Mailing Address ☐ Check if same as above

Street Address Apt# City/Town State/Region Area Postal Code Country

Other information:

E-mail Address	Preferred Communication Type: ☐ E-mail ☐ Phone ☐ Mail	Resident of

Language preference if not English	Citizen of

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company
Dental coverage provided by UnitedHealthcare Insurance Company
Life and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | ☐ Spouse ☐ Domestic Partner (if eligible) | Birthdate / / mm dd yyyy

Preferred mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) | Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent** | Birthdate / / mm dd yyyy

Preferred mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) | Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent** | Birthdate / / mm dd yyyy

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) | Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent** | Birthdate / / mm dd yyyy

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) | Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

☐ Enroll ☐ Cancel ☐ Change | Last Name | First Name | MI | Sex ☐ M ☐ F | Dependent** | Birthdate / / mm dd yyyy

Preferred Mailing address | Apt# | City/Town | State/Region | Area Postal Code | Country

Social Security Number (U.S. only) | Race – Check all that apply (Optional)*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify

*Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their health and well-being and not for eligibility or claim payment determination.

**For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	LTD	Life/Amount	AD&D	Dual Option Selected
Subscriber	☐	☐	☐	☐	☐ $ __________	☐	☐
Spouse	☐	☐	☐		☐		
Domestic Partner	☐	☐	☐		☐		
Dependents	☐	☐	☐		☐		
					Salary __________ Required only if Life Plan based on salary		

Life Insurance Beneficiary's Full Name and Address | Relationship

[XXX-XXXX 3/15]

D. Reimbursement options

Pay Member

☐ Use banking details on file ☐ Payment by check ☐ Electronic funds transfer payment

Specify currency for reimbursement _____ Note - If no selection, reimbursement will default to a US dollar check

For bank transfers please complete the following:

Bank name _____

Bank address _____

SWIFT / BIC Code _____

Beneficiary routing code _____

Account number / IBAN _____

Account name / Payee _____

E. Other Medical or Other Country Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical or country health plan or policy, including another UnitedHealthcare plan or Medicare?

☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier or other country coverage:

Other Group Medical or Other Country Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

* B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

F. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.
I acknowledge that I have received the "Important Information" statement which is included with this form.

Subscriber Initials	Date

G. Signature

I confirm that the information I have provided on this form is complete and accurate.

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date	Subscriber Signature for all applying and waiving	Spouse Signature (if applying for coverage) (Spouse may include a Domestic Partner, depending on your benefit plan)

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our subscribers or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

[XXX-XXXX 3/15]

SERFF Tracking #:	*INCS-130800949*	***State Tracking #:***		***Company Tracking #:***	*POL.STT.I.13.F*

State:	*District of Columbia*	***Filing Company:***	*UnitedHealthcare Insurance Company*
TOI/Sub-TOI:	*H19G Group Health - Travel/H19G.000 Health - Travel*		
Product Name:	*UHC Short Term Travel*		
Project Name/Number:	*UHC POL.STT.I.13/UHC POL.STT.I.13*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking #:	*INCS-130800949*	***State Tracking #:***		***Company Tracking #:***	*POL.STT.I.13.F*

State:	*District of Columbia*	***Filing Company:***	*UnitedHealthcare Insurance Company*
TOI/Sub-TOI:	*H19G Group Health - Travel/H19G.000 Health - Travel*		
Product Name:	*UHC Short Term Travel*		
Project Name/Number:	*UHC POL.STT.I.13/UHC POL.STT.I.13*		

Supporting Document Schedules

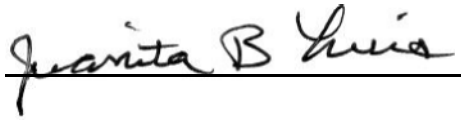
Satisfied - Item:	authorization letter
Comments:	
Attachment(s):	ICS Authorization - UHC 2016.pdf
Item Status:	
Status Date:	

Satisfied - Item:	readability certification
Comments:	
Attachment(s):	Readability DC.pdf
Item Status:	
Status Date:	

Satisfied - Item:	cover letter
Comments:	
Attachment(s):	Form Letterhead.pdf
Item Status:	
Status Date:	

COMPANY: **UnitedHealthcare Insurance Company**
NAIC Number: 79413
FEIN Number: 36-2739571

Please accept this letter as authorization for **Innovative Compliance Solutions, LLC** to act as our agent for submission of policy forms and rate information and to perform each and every act necessary in connection with such submission on behalf of **UnitedHealthcare Insurance Company**.



SIGNED BY: Juanita B. Luis

TITLE: Assistant Secretary

UnitedHealthcare Insurance Company

DATED: 1/12/2016

CERTIFICATION OF COMPLIANCE FOR READABILITY

I hereby certify that the forms referenced below meet the minimum reading ease score on the test and are readable under the rules and standards of your state.

Group Policy,	POL.STT.I.13.DC	Flesch score: 49.1
Certificate of Coverage,	COC.STT.I.13.DC	Flesch score: 44.6
Schedule of Benefits,	SBN.STT.I.13.DC	Flesch score: 47.2
Accidental Death and Dismemberment Rider,	STT_I_13_ADD_RID.	Flesch score: 48.9
Insured Employer Application,	LG.ER.15.GS.DC 3/15	Flesch score: 50.2
Insured Short Term Travel Employer Application,	LG.ER.15.GS.STT.DC 3/15	Flesch score: 50.2
Employee Application	LG.EE.15.GS.DC 3/15	Flesch score: 52.5

Signature:_____ Date 11/8/16

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UnitedHealthcare Insurance Company
NAIC No. 79413
H19G.000 Travel
Group Short Term Travel Product Filing

On behalf of UnitedHealthcare Insurance Company, Innovative Compliance Solutions, LLC is submitting the enclosed group Short Term Travel product for your Department's review and approval. An authorization letter is attached.

This is a new product form filing. The rates for this product were filed under SERFF filing number INCS-130800948.

Our intent is to use these forms for fully insured large employer groups only. The enclosed forms include:

Group Policy, POL.STT.I.13.DC
Certificate of Coverage, COC.STT.I.13.DC
Schedule of Benefits, SBN.STT.I.13.DC
Accidental Death and Dismemberment Rider, STT_I_13_ADD_RID.DC
Insured Short Term Travel Employer Application, LG.ER.15.GS.STT.DC 3/15
Insured Employer Application, LG.ER.15.GS.DC 3/15
Employee Application, LG.EE.15.GS.DC 3/15

The Short Term Travel product provides business travelers who require temporary coverage while travelling outside their home country. The Short Term Travel product is a fully insured supplemental product that provides coverage in addition to a group's base medical product. As you know, supplemental travel plans are excepted benefits and are not required to comply with ACA requirements.

Some of the Core and Optional coverage highlights are noted below:

Core Coverage:
• Worldwide coverage for emergency and urgent care medical services due to accident or sickness while travelling outside the home country
• Suite of standard plan designs to be offered with medical limit maximums from $100,000 to $500,000
• Evacuation Benefits (emergency medical evacuation, medical repatriation and return of mortal remains)
• Global concierge and travel assistance services (e.g., legal referrals and emergency translation services)

Optional Coverage:
• Accidental Death and Dismemberment (AD&D)
• Dependent Coverage
• Sojourn Travel (leisure travel in conjunction with a business trip)

Explanation of Variable Text
The form is made up of:
• Nonvariable Text that always appears in an issued document.
• Variable Text that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets]. Variable text will appear unbracketed in the final documents issued to the employer and/or member.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Renee Weaver

Renee Weaver
Consultant
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